SPECIAL ARTICLE

The art of psychiatry

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Psychiatrists would undoubtedly support the notion of promoting such qualities as empathy, sensitivity and caring in the pursuit of good clinical practice. However, cultivating what we may call the "art of psychiatry" is not straightforward, since the qualities that constitute it are elusive. I propose that the means by which we can accomplish the goal of relating empathically and compassionately to our patients and their families is by regarding the humanities and the sciences as of equal relevance and as complementary. The humanities, particularly literature, the visual arts, film and music, are most suited to promoting empathic skills when they are woven into the clinical scenario. Examples are provided to demonstrate how this may be achieved. Were we to succeed in highlighting the art of psychiatry in our educational programs, and as part of continuing professional development, I surmise that our patients and their families would be the beneficiaries. We cannot merely vow to act empathically and sensitively. Instead, we should embark on a lifelong journey through the wonderful world of literature, the visual arts, film and music. The experience will not only prove appealing and engaging, but it will also go far to enrich our personal and professional lives.

Key words: Science of psychiatry, art of psychiatry, empathy, evidence-based mental health

All psychiatrists would undoubtedly support the notion of promoting such qualities as empathy, sensitivity and caring in the pursuit of good clinical practice. However, a snag complicates this task, namely the elusiveness of these qualities. For example, is it a question of "you have them or you don't"? Can these qualities be learned? If so, how? I would like to address these matters by focusing on what we may call the "art of psychiatry" and argue for a role for the humanities in enhancing it.

Paradoxically, the art of psychiatry warrants our attention more than ever before when it is juxtaposed alongside the rapid strides we have made in advancing the profession's scientific basis. We can now peer into the brain and examine its function with sophisticated imaging technology. We are poised to learn much about the contribution of genetic factors to mental illness. We have a range of psychotropic medications and psychotherapies, which have been demonstrated to be effective in a growing proportion of patients. Notwithstanding this rosy picture, a caveat intrudes. Anna Freud once noted that "many doctors... are not primarily healers. They want to know, they want to figure out, they take pleasure in fixing something..." (1). Of course, there is nothing inherently wrong with fixing, but, in psychiatry, arguably the most person-oriented of all the medical specialities, it can be at the expense of the two features Anna Freud pinpoints as key ingredients of healing: empathy and compassion.

EVIDENCE-BASED MENTAL HEALTH: A MIXED BLESSING

As part of fixing, many doctors are attracted to a prominent feature in the contemporary professional landscape: evidence-based medicine. While this is a noteworthy development, we do need to appreciate its limitations, even its potential deleterious effects. We should certainly apply only those treatments resting on adequate levels of evidence, whether through randomised controlled trials or consistent clinical observation. Innovative therapies also should have a place, but then earn it by being evaluated systematically.

There is an intrinsic irony here. Any well-informed clinicians should only resort to procedures and treatments which are buttressed by objective data, the more robust the better. But, perturbing about the veritable frenzy regarding evidence-based medicine is the omission of the obvious fact that, as Michael O'Donnell so aptly puts it, "evidence-based medicine deals with populations; clinicians deal with individuals" (2). Psychiatrists would also be more aware than any other medical specialists that these individuals are unique in terms of the interplay of their biology, psychology, social circumstances and, some have asserted, spiritual life.

Martin Van der Weyden, editor of the Medical Journal of Australia and an enthusiast of evidence-based medicine, is also mindful of its snares when he regrets: "Nearly extinct are accounts of the clinical art of medicine – the understanding and unravelling of medical problems through cumulative experiences with patients, a clinical tradition reaching back through Osler ... to Hippocrates" (3). Van der Weyden could well have cited Maimonides, the great Jewish physician of the Middle Ages who, in his espousal of a holistic clinical approach, proclaimed: "Any sick individual presents new problems. One can never say one disease is just like the other... The physician should not treat the disease but the patient who is suffering from it" (4).

THE CASE FOR THE ART OF PSYCHIATRY

I hope this brief critique finds the reader's favour since it makes my case to promote the art of psychiatry all the more imperative. Let us now tackle this dimension of clinical practice. I contend that the means by which we can accomplish the goal of relating empathically and compassionately to our patients and their families is by regarding the humanities and the sciences as a) of equal importance and b) as complementary. I enjoy the support of illustrious colleagues in this view.

The eminent American ethicist Edmund Pellegrino, for instance, avows that "medicine enjoys a unique position among disciplines ... as a humane science whose technology must ever be person-oriented..." He likens medicine to the arts in providing "a kind of human experience that makes it a special medium for revealing the world ... it [yields] an aesthetic wisdom of its own special object, man" (5).

Sir Kenneth Calman, a leading figure in British medicine, highlights the characteristics of an educated doctor: "someone who not only has the requisite clinical skills, knowledge and experience, but also can appreciate each patient as an individual human being with thoughts and feelings, and can understand and help explain illness and suffering" (6). Calman proposes that the humanities not only have a central role in moulding doctors with these characteristics but are "also relevant for personal continuing professional development".

Both sets of goals, laudable as they are, are likely to blur into each other if we link psychiatry and the humanities in too diffuse a fashion. I see empathy as the shared foundational feature, since it undoubtedly lies at the heart of the clinical encounter and complements the scientific attitude of developing and applying knowledge objectively and creatively.

Empathy, surprisingly, is a new word to the English language. Derived from the Greek *em*-into, *pathos*-feeling, empathy denotes an emotional process through which we place ourselves in another person's internal world and thereby experience that world vicariously. We do not do this for its own sake but as a means to accomplish an accurate understanding of what the experience is like for the other person. Referring to the process by its more accurate German term, *Einfühlung*, literally "feeling into", Sigmund Freud states that it "plays the largest part in our understanding of what is inherently foreign to our ego in other people" (7).

Thus, as we listen to the stories of patients and their families – whether it be a widow's grief upon the suicide of her husband, an adolescent's struggle to confront his heroin addiction, a Holocaust survivor sharing his guilt at living while his entire family has perished, the torment of a person with schizophrenia fending off persecutory demons, a couple's distress in coping with the diagnosis of anorexia nervosa in their daughter (the list is endless) – we use empathy in striving to understand what people are experiencing behind their narratives. I would suggest this is a *sine qua non* of all healing responses. The French historian Marcel Bloch refers to his craft in a way which is remarkably apt for the psychiatrist who, in a pivotal sense, also occupies the role of historian. After all we refer to history-taking, family history, developmental history and the like. Bloch points out: "When all is said and done, a single word, 'understanding', is the beacon light of our studies" (8). It is empathy which leads us to this beacon in psychiatry.

PROMOTING EMPATHIC SKILLS THROUGH THE HUMANITIES

I turn now to how we may promote empathic skills through the humanities, whether at the undergraduate, postgraduate or continuing professional development level (like Calman, I see this as a lifelong endeavour). Several methods are available to achieve understanding of the other. Role-plays, for example, are most effective. I will not easily forget a student portraying (without any preparation) a patient who had shared her story of severe postnatal depression in an interview the previous day. I could have sworn the student herself was the sufferer. Indeed, my impression is that medical students and psychiatric trainees thrive when using these dramatic devices, leading me to wonder if they are not starved of the opportunity to be imaginative and creative during their long period of education.

Another strategy is the live interview of the patient in which he is encouraged to convey not just a story but the feelings that accompany it. Here again, our students can become proficient in listening to the narrative with a "third ear". When I therefore advocate a role for the humanities in enhancing an empathic, caring attitude, I mean them to supplement these traditional learning methods.

As to who should highlight the humanities, I propose that sensitive clinical psychiatrists with a commitment to the art of psychiatry are well placed, since they are intimately aware of the part empathy and related understanding play in their work. Given this advantage, they can extract pertinent material from the inexhaustible riches of the arts. Moreover, they may do so in conjunction with their colleagues in University arts faculties as well as with creative artists like writers, dramatists, poets, film-makers, painters and musicians.

The humanities should, ideally, be woven into the clinical scenario. That trainee or consultant psychiatrists shift away from the clinic or ward to participate in a separate course may be appropriate for those wishing to sharpen their literary skills or nurture a writing talent, but not for the purposes I am propounding here. They need to be struck forcibly by the relevance of the experience, with explicit mention of the clinical issues illuminated by a particular short story, painting, film and so forth.

Consider the role of film to explore the psychological lives of diverse people. *Shine*, for example, directed by Scott Hicks, strikingly portrays the anguish of a family – including the principal protagonist, David, played in an Oscar-winning performance by Geoffrey Rush, who becomes psychotic – in which all members struggle to deal with the insecurity of a pitiful, yet tyrannical, father and husband. The challenge of understanding all the *dramatis personae* (and their interactions) without becoming judgemental is readily facilitated by watching this emotionally powerful film. We also discover the ease with which the purportedly objective, detached professional may side with some family members at the expense of others. The film

Spider, directed by David Cronenberg, is a remarkable portrait of a chronically ill patient, played by Ralph Fiennes, who is "discharged" into the so-called community, only to experience his torment in a new utterly solitary way.

The visual arts are especially conducive to the study of mental states, both the artist's and those of his creation. Norway's most celebrated painter, Edvard Munch, lends himself well to the interplay between the inner life of the artist and what he portrays on canvas. By viewing a series of his paintings, we soon note a poignant theme pervading the work: melancholy, loss and alienation.

We may also take the opportunity to explore paintings done by patients during the course of their illness and rehabilitation in order to see how these shed light on their internal world. By peering "beyond the surface", we have the incomparable means to enter into a range of psychological domains and penetrate their innermost core.

It is not surprising that most practitioners who draw on the humanities in their clinical work or teaching to optimise the art of psychiatry choose literature as their primary source. After all, we mostly use words to relate to our patients and rely on oral testimony when we elicit a clinical history. Consider one such clinical story. One of three sons, John, stood out as an intelligent and sociable young man. Attracted to the law, he graduated well and obtained a satisfying job. He performed his duties with an exactness and honesty of which he could feel proud. Outside of his profession he was witty and good-natured, although given to touches of vanity. After John had served his firm commendably for five years, he was offered a post in a higher court; his duties became more interesting and challenging.

Having settled down pleasantly in a new town, he met his future wife, an attractive girl in the set in which he moved. Marriage soon followed. Regrettably, from the first months of his wife's pregnancy, their relationship became strained, since she found fault with everything. Further troubles ensured upon the birth, both real and seemingly imaginable illnesses, in both mother and baby. As his wife grew more fractious, so John turned more to his work, becoming more ambitious than before. The result was another promotion. Meanwhile, more children came but bringing greater maternal ill-temper. Most conversations were disputatious.

We jump to the 17th year of marriage, when John achieved unexpected success. He was elevated to a high-ranking job which brought him considerable esteem. He was completely satisfied. The marriage also improved then that the family were living in a lively, metropolitan city. This happier time was marred however when he slipped off a ladder. Only a minor injury followed; the pain soon passed. Indeed, he felt bright and well just then. Moreover, he thought how fortunate he was to be something of an athlete. Another man falling as he had done might well have been killed. So, setting aside any concerns about his injury, he felt in a good humour.

But the discomfort in his left side persisted, even worsened. To this was added a queer taste and growing irritability. Quarrels between husband and wife intensified. At times he would fall into a rage, so much so that his wife began to feel pity for herself and exasperated with her husband. On one occasion she insisted he see a doctor. He pronounced a need for tests. John wasn't terribly taken with the doctor's jargon but much concerned about his indifference to what he regarded as a key question: was his case serious or not? All the way home he tried to translate the obscure phrases into plain language and find in them an answer to the questions: "Is my condition bad? Is it very bad? Or is there as yet nothing much wrong?" It seemed to him that the meaning of what the doctor had said was "that it was very bad".

He followed the doctor's directions. Indeed, he obeyed orders diligently and derived comfort from doing so. The pain, however, did not diminish. John made efforts to force himself to think that he was better. And he could do this as long as nothing agitated him. But once he had any unpleasantness with his wife, any lack of success at work or a bad hand at bridge, he was acutely sensitive to his medical condition. After he consulted another doctor, it seemed to him that he was deteriorating, and very rapidly at that.

He consulted a renowned physician, who conveyed almost the same information as the very first had done, which had the effect of increasing his fears. A friend of a friend diagnosed his illness differently; further doubts arose. A homoeopath viewed the disease in yet another way and prescribed medicine which he took secretly. Not feeling any better and having lost faith in all treatments, he became more and more despondent. As time passed, it seemed to him that he was on the brink of an abyss, with no one able to understand him.

On one particular evening, when attempting to fall asleep, the whole experience presented itself in a new way. It was not a question of this or that organ but one of life and death. Life was there and now it was going, and he could not stop it. He wondered if it was not obvious to everyone but himself that he was dying; it was only a question of weeks, even days. Previously, there had been light, now there was darkness. He resented those around him; his dying was all the same to them but they would die too. Perhaps he would go first but they would follow later and it would be the same for them.

John then saw that he was indeed dying and was in continual despair. He slept poorly. He was on continuous morphine. All food tasted disgusting. He felt a dull depression. What tormented him most was the deception that he was simply ill, and only needed undergo treatment and then something good would result. This deception tortured him. What also hurt John was that no one pitied him as he wished to be pitied. He hoped most of all for someone to comfort him as a sick child is comforted.

Consultation with a renowned specialist provoked new feelings of fear and hope. The doctor could not vouch for it but there was a chance of recovery. But the gleam of hope did not last long. The same room, pictures, curtains, wall paper, medicine bottles were all there, as was the same suf-

fering body. He now felt helpless and lonely, and could only think of the cruelty of God, even of his absence.

Morphine soon proved inadequate and his pain became horrendous. After three dreadful days his school boy son crept into the sick room and encountered his father screaming plaintively. John looked at the boy and felt sorry for him. He thought to himself that it would be better for them when he died. Suddenly it grew clear what had been oppressing him; he was sorry for them, must act so as not to hurt them, and release them and himself from these sufferings.

He sought his former accustomed fear of death and did not find it. In place of death there was light. This happened to him in a single instant. For those present his agony continued for another couple of hours. Something rattled in his throat, his emaciated body twitched, then the gasping became less frequent. "It is finished!" whispered someone. He heard these words and repeated them in his soul. "Death is finished" he said to himself. He drew in a breath, stopped in the midst of a sigh, stretched out, and died.

Readers acquainted with Tolstoy's (9) short story *The death of Ivan Ilych* will have already guessed that John emanates from the imagination of the great novelist. *Ilych* is an acclaimed account of the experience of facing death, replete with psychological and philosophical insights, the like of which have rarely been matched. No reader can fail to be stirred by Ilych's initial anxious wriggling away from the threat of death, his later despair, and his ultimate sense of acceptance. The story paves the way for a consideration of how to relate to the seriously ill person. We also obtain a graphic account of a severely dysfunctional family's failure to deal with their loss. The latter has proved indispensable in our own efforts to empathize with a family's anticipatory grieving and to devise a form of family therapy which could be of help to those families which are floundering (10).

With Tolstoy in mind, we may return to our theme of promoting a role for the humanities in psychiatry through literature. An infinite body of writing is available. Two categories stand out. The first are the novels, short stories, plays and poems of gifted writers. Shakespeare is arguably the most insightful "psychologist" of all time. Hamlet, King Lear, Macbeth and Lady Macbeth, Shylock, and dozens of other characters reveal variegated facets of human motivation and conflict. In more modern times, the Loman family in Arthur Miller's *Death of a salesman* and the Tyrones in Eugene O'Neil's *Long day's journey into night* are masterful in highlighting the complexity and tragedy of severe family dysfunction.

The second category of literature, suitably entitled "testimonial" in that its authors share their personal encounters with illness, has expanded enormously in recent years. Those who have been afflicted and able to communicate the nature of their experience usually do so with searing honesty. *Darkness visible*, for instance, is a courageous account by the novelist, William Styron (11), of his suffering from suicidal melancholia. *An unquiet mind* is a set of vivid revelations of the vicissitudes of wrestling with manic-depressive illness by Kay Redfield Jamison (12). The Melbourne historian Inga Clendinnen (13), in her acclaimed memoir *Tiger's eye*, has woven into the narrative an emotionally evocative account of her battle to survive a life-threatening illness and liver transplant.

Testimonial literature also encompasses the observations, insights and personal encounters of relatives of the mentally ill. An account of family life where a member suffers from the ravages of schizophrenia, *Tell me I'm here*, by the Australian journalist Anne Deveson (14), is unsurpassable in illuminating what tragic effects a son's intractable condition may have on his loved ones. *Romulus, my father*, an inspiring memoir by the moral philosopher Raimond Gaita (15), is equally poignant.

Poetry is another means of appreciating the experience of mental illness. Sandy Jeffs, a prize-winning poet who has grappled with schizophrenia for over quarter of a century, retains the talent of sharing what it is like to be trapped within the vortex of a psychosis. One of her poems is aptly entitled *Psychotic episode* (16) (see Table 1).

THE PSYCHOBIOGRAPHICAL APPROACH

A counterargument to resorting to either the great writers or to testimonial literature could be made. Most of us are intrigued by our patient's own stories. We merely have to take the time to listen to them. The tradition of delving into the psychobiographical is a rich one, going back to a towering figure in American psychiatry, Adolf Meyer. As he stresses: "We study the biography and life history, the resources of adaptation and of shaping the life to success or to failure... What a difference between the history of a patient reported and studied ... by the well-trained [physician] ... and the account drawn up by the statistical-minded researcher or the physician who wants to see nothing

Table 1 The poem *Psychotic episode* by Sandy Jeffs

When the chilled, icy wind blew,
in went I,
into a world I knew nothing about,
into a space for which I could
never have prepared myself even if
I had been warned of its existence.
Down, down, down went I,
tumbling into an abyss filled
with a myriad spooks and phantoms
which preyed upon my unsuspecting self.
There was no room for rationality,
only chaos upon chaos upon chaos,
and flowing rivers of turbulent waters flanked
on each side by Gothic mountains of angst.
And I was immersed in something
deeper than a huge black hole,
from which I did not emerge
until the haze was blown away
by all manner of processes that acted upon my distraught,
disturbed self.
But as the wind wuthered about my cardboard face,
a chill had set in and frozen my life force forever.

but ... chemistry and internal secretions...” (17).

Another doyen of American psychiatry, John Nemiah, dwells on a similar theme as well as forging the link between patient as story teller and physician as empathic listener: “The subject of observation (the living, experiencing human being) dictates the methods of observation. They are made within the context of a human relationship between the patient and ourselves, in which we must immerse ourselves in the patient’s life and must empathically feel our way into his experiences” (18). Nemiah graphically illustrates his position by telling the story of one of his patients, Grace Carbone. He does so in such a captivating way that it amounts to a fine literary work (indeed a reminder of Freud’s case histories). In his review of “the panoramic sweep of her life”, Grace comes fully alive. She is no longer a case or a diagnosis, but a person with a story who promotes our curiosity to learn more about her inner world and our motivation to relieve her suffering.

We may therefore pose the question: why turn to “external” literature when we can elicit our own by attending sensitively to stories emerging in the clinic? The answer is obvious if we consider the question in the light of earlier argument. The scientific dimension of psychiatry constantly tugs us towards the “facts”, statistical norms, diagnostic criteria. On the other hand, acquaintance with great and testimonial literature (and other forms of art) encourages us to achieve what Meyer and Nemiah claim is the foundation of the psychiatrist-patient relationship: getting in touch with the living, experiencing human being. A corollary is that we master the complementarity of science and art, retaining in each case their full measure of relevance and applicability.

CONCLUSION

I have advanced the case for weaving the humanities into the practice of psychiatry. Were we to achieve this, I surmise that the art of our discipline would be much enhanced, with corresponding benefits for patients and their families. I have highlighted empathy as the key quality which we need to foster in ourselves. But one cannot merely vow: “I shall be empathic”. Instead, we need to journey through the wonderful world of literature, the visual arts, film and music. Not only will that journey prove inherently appealing and engaging, but it will also go far to enrich our personal and professional lives. Bon voyage!

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